The development and clinical evaluation of a 'traffic-light' design dermatology outpatient discharge information checklist

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SUMMARY

Background
Although multiple factors influence discharge decisions, there is no structured guidance to assist clinicians in making informed decisions. A discharge information checklist might improve the appropriateness of dermatology clinicians' discharge decisions.

Objectives
To generate consensus among dermatologists on the content of an outpatient discharge checklist, to create one and to seek clinicians' opinions on its usefulness.

Methods
Seventeen consultant dermatologists from five National Health Service trusts completed a 72-item Delphi questionnaire. A five-point Likert scale was used to rate each item for importance in contributing to a high-quality discharge decision. Eighteen clinicians completed a questionnaire evaluating checklist use.

Results
Consensus was determined when ≥ 75% of consultants rated an item 'very important' or 'important'. There was strong inter-rater reliability (intraclass correlation coefficient = 0·958) and fair inter-rater agreement (Fleiss kappa = 0·269). There were 26 consensus-agreed items, condensed to 13 that formed the 'traffic-light' checklist. These are disease-related issues (diagnostic certainty, disease severity, treatment appropriateness, patient manageable in primary care, patient's benefit from follow-up), patient empowerment issues (understanding diagnosis and treatment outcome, having a clear plan, treatment side-effects, ability to self-manage) and addressing concerns (patient concerns, easy reaccess to secondary care, whether patient and clinician are happy with the decision). Twelve clinicians (67%) found the checklist useful, 11 (61%) wanted to use it in future, 10 (56%) thought it was useful for training and three (17%) said it helped their thinking. Clinicians suggested its use for auditing and for training clinicians and administrators.

Conclusions
Items were identified to create an outpatient discharge information checklist, which demonstrated high acceptability.

The decision to discharge a patient from an outpatient clinic is one of the most common decisions taken in clinical practice. These decisions have a profound impact on the efficiency of outpatient clinical services, as well as on the nature and appropriateness of individual patient care. Despite this there is very little information about how discharge decisions are taken, [1-7] and the process is mostly completely unstructured and left to the individual judgement of clinicians. In the real world of the

National Health Service, clinicians are often influenced by hospital policies and commissioners, which pressure them to provide adequate slots for new patients rather than for follow-ups.[2] Twenty-three consultants stated that they were pressured by hospital mangers to meet targets for new to follow-up patient ratios of outpatient attendances. [2] This pressure makes it all the more important that clinicians carry out the process of discharge decision taking in a structured and informed way, in order that such decisions are taken to meet the best interests of the individual patients. The identification of the critical information needed to take an appropriate discharge decision may assist clinicians to perform better patient discharge.

Although there has been a focus on how to plan discharge of in-patients [8-12] there is little information about discharging outpatients. Clinicians may neglect potential risks surrounding discharge decisions. [2] Some clinicians feel self-assured by their clinical intuition [2, 13] or project overconfidence, [2, 14] while others may be biased by patients' attitudes at discharge. [2, 4] Junior clinicians may review patients indefinitely. [2, 4] Clinic time constraints, [1-3] consultations with 'demanding' patients [2] and pressure to conform to discharge policies [1, 2] may contribute to premature discharges. Delayed discharge can occur when clinicians have a close relationship with a patient, [2] or if they procrastinate over writing discharge letters. [4] We have identified a wide range of clinical and nonclinical influences on discharge decision taking, some inappropriate. [2] In the interests of patients and of efficient service provision, there is a need to assist clinicians in taking high-quality discharge decisions. [1-3]

A 10-item inpatient checklist has been proposed by a patient liaison group [15] to support inpatients before they leave the hospital. Other checklists have been suggested to ascertain diagnostic criteria, [16] to improve patient safety during operative crises [17] and to prevent surgical complications. [18, 19] Outpatient discharge checklists have been developed for use in medical, [20] surgical, [21, 22] emergency, [23] and post anaesthetic settings, [24] but there is none for dermatology, other than guidelines on the length of skin cancer follow-up. [25, 26] The aim of this study was to create a consensus-based discharge checklist for use in dermatology outpatients, and to gather clinician feedback on its use.

MATERIALS AND METHODS

This study had two stages: the creation of a discharge checklist using a Delphi exercise and the evaluation of its usefulness. The study was conducted by N.A.H., a clinician with dermatology training. The South-East Wales Research Ethics Committee and the research and development departments of five hospital National Health Service trusts granted ethical approval and permissions. The Delphi technique (Fig. 1) was chosen for its suitability to elicit consensus from experts. [27-32] It allows iterative, structured feedback between the researcher and respondents while preserving anonymity, [33] and minimizes the influence of dominant respondents [32] Consultants gave written consent and were identified by code number for data protection and confidentiality.

Selection of the panel of consultants

Appropriate selection of raters (i.e. consultants) is the most crucial step of the Delphi process because it directly influences the results. Although guidance about selection is lacking,[31] we focused on participants who were highly engaged, well trained and competent[29] in discharging outpatients. The selection aimed for a mix of consultant dermatologists from different trusts across England and Wales and with differing special interests.

The Delphi process

Round one

The Delphi questionnaire was prepared using information from a literature review[1] and earlier interviews with consultant dermatologists[2] and patients.[34] The consultants (raters) were asked to rate the importance of items as information necessary to carry out a high-quality discharge, using a Likert scale of 1 (unimportant) to 5 (very important). Written comments were encouraged.

Round two

The raters were given their previous ratings and the group's median ratings from round one. Raters were asked to rate the items again, altering their ratings if they wished.

Round three

The raters were again given their previous ratings and the group's median ratings from round two, and asked to rate the items for the third time (Fig. 2).

Statistical analysis

Consensus was defined using subjective criteria and descriptive statistics. Three rounds of questioning were considered to be sufficient to establish consensus,[35] defined as ≥ 75% agreement in the options 'very important' and 'important'.[10, 24] The medians and interquartile ranges were used to determine consensus.[35, 36] The intraclass correlation coefficient (ICC) was used to measure the inter-rater reliability, as the study involved ordinal or natural ordering data[37] and the ICC is suitable for multiple raters.[37] Data were assessed using the two-way random effects model.[37] The Fleiss kappa[37, 38] was used to calculate the inter-rater agreement because of the fixed number of multiple raters.[35, 37] SPSS Statistics software version 20 (IBM, Armonk, NY, U.S.A.) was used for the ICC analysis.

Checklist design

The creation of the checklist followed a content-related approach incorporating all suggestions for a DO-CONFIRM checklist.[39] The items identified from the Delphi exercise were reduced by N.A.H. to a smaller practical number by 'coalescing' similar items. The checklist design was developed by N.A.H., A.Y.F. and M.S. with assistance from three colleagues (see 5).

Content validity, practicality and applicability of the checklist

In a pilot study, six clinicians answered a four-item questionnaire: whether they found the checklist useful, whether it helped in their thought processes, whether the items in the checklist were inadequate and whether they would like to use the checklist in future consultations. Further changes were made based on their comments on its content, wording and design. Five of the six clinicians were invited again with another group of 13 clinicians to use the checklist during one dermatology outpatient clinic. N.A.H. explained how to use the checklist, using an instruction sheet (Appendix S1; see Supporting Information), twice in advance by e-mail and then immediately before each clinic. N.A.H. attended the clinics as a nonparticipant observer.

RESULTS

Delphi study

All 17 raters (100%) answered the Delphi questionnaire in all three rounds. During the Delphi process delays in receiving responses required reminders to raters. Twelve (71%) of the raters were male, with an average age of 48·7 years (range 36–65) and dermatology experience of 9–23 years. Fifteen of the consultants who took part in the three-round Delphi exercise were practising in major centres in university teaching hospitals (Cardiff, Birmingham, Bristol and Oxford) and two

consultants were practising in a major district general hospital (Gloucester). All consultants were involved in teaching students and specialist trainees. The consultants differed in their main specialties: the main specialty interest of five consultants was medical, for six it was surgical and for six it was paediatric dermatology.

Consensus was achieved in the third round. There was strong inter-rater reliability (ICC = 0·958). The Fleiss kappa, calculated using the '*r*' measure, was 0·122 (round 1), 0·250 (round 2) and 0·269 (round 3), indicating 'fair' inter-rater agreement.[38]

At the end of round three, 26 items with ≥ 75% agreement qualified for inclusion in the checklist shown in Table 1, which gives their percentage agreement and interquartile range. Thirteen of the 26 items had a level of agreement of 100% with an interquartile range of 4–5. The 10 ranked as 'very important' had a small degree of variance (range 0·11–0·34), indicating high agreement among raters. While 26 items qualified for consensus, items with related meanings were combined and were grouped together under one statement, resulting in 13 statements (Table 2). For example, the statement on 'patient concerns' included patients' psychological and carer concerns, and patients' wishes not to be followed up or wishes to be followed up by their general practitioner. The 13 discharge checklist statements were categorized as (i) disease related (five items): certainty of diagnosis, disease severity, appropriateness of treatment, patient manageable in primary care and patient's benefit from follow-up; (ii) patient empowerment (four items): patients' understanding of the diagnosis, prognosis and treatment side-effects, the availability of a clear plan and the patient's ability to self-manage; and (iii) patient concerns (four items): concerns of the patient, patients' ease of reaccess to secondary care, and whether the patient and clinician are happy with the decision to discharge.

Checklist design

The 'traffic-light' design checklist (Fig. 3) encompassed key areas appropriate in any patient–physician shared decision-making process,[40] including diagnosis, aetiology, prognosis, treatment options and outcome probabilities. In addition, the checklist covered two aspects of patient expertise: their ability to self-manage and their concerns. The final checklist statement 'Am I happy to discharge the patient?' follows DO-CONFIRM guidance.[39] The checklist was designed to fit on one page and words were chosen to be exact and easy to read, using a sans serif type.[39] Although five to nine items is the ideal for a checklist, it was felt that further reduction would affect the checklist quality.

Content validity, practicality and applicability of the checklist

Initial pilot study

Six clinicians completed the pilot study. Four thought the checklist relevant and useful, one stated it helped one's thought process, none thought the 13 items were inadequate and four said they would like to use the checklist. All thought there was no need to add more items. One felt the checklist was aimed at 'medical' rather than 'surgical' consultations. Five clinicians liked the checklist design and felt it was clear and easy to use and took little time.

Clinical assessment

The checklist was evaluated by 18 clinicians (Table 3), using a four-item questionnaire and giving free-text comments (Table 4). Twelve (67%) clinicians reported the checklist as useful. One said that it helped in dealing with discharging 'difficult patients' and one viewed it as a reminder during the discharge decision process. Six (33%) of the 18 clinicians would use it if uncertain about discharge; however, five (28%) of them thought that time constraints might limit its actual use. Six (33%) stated that it was not useful, as making discharge decisions was normal routine practice. Another said the checklist was not useful for dilemmas such as consideration of budget constraints or patients'

insistence on follow-up. One clinician felt the item 'easy reaccess of care' was wishful thinking in their clinic organization. Only three (17%) clinicians (two with > 20 years' clinical experience) stated that it guided their thoughts. Ten of the 15 clinicians who felt the checklist did not help in their thought processes expressed confidence in their present decision taking and felt that they subconsciously thought of the checklist items anyway.

No clinician felt that the checklist items were inadequate; however, four (22%) suggested slight modifications. One suggested merging items into seven statements and one suggested adding the descriptor 'serious diseases' so as also to encompass early melanomas. The other two clinicians suggested adding 'not applicable' as a response option for some items. Five (33%) clinicians liked the simple, crisp appearance of the checklist. Other suggestions included the use of the checklist for discharge audit purposes and to help hospital managers understand how clinicians take discharge decisions. Two clinicians stressed the importance of obtaining direct feedback from patients so that clinicians are aware of their 'discharge performance'. Four (22%) felt that the checklist would be useful as a safety net when discharging patients, in structuring consultations and setting patients' expectations. Ten (56%) clinicians suggested using the checklist during training of clinicians and one suggested a study of such use. Two consultants suggested that the printed checklist should be laminated and available on the clinician's desk or attached to patient notes as a prompt at every new referral. One nurse said that the checklist reminded her of the need to ensure that patients were educated about their treatment before discharge. One consultant suggested the possibility of developing a disease-specific discharge checklist to justify appropriate follow-up.

DISCUSSION

This paper describes a novel structured method of checking that the appropriate information is available on which to base outpatient discharge decision taking. The appropriateness of the checklist criteria has been confirmed, but a prospective controlled study is needed to confirm its practicality and value.

The consultants who took part in the Delphi exercise were working mostly in teaching hospitals. It is possible, but unlikely, that they may see a different case mix of patients compared with clinicians working in smaller or district general hospitals; this comparison was not carried out in this study. Consultants in teaching hospitals often find difficulty in balancing the workload pressure of busy clinics with student teaching.[4, 5] They sometimes appeared rushed during discharge consultations.[34] The case mix of patients may influence clinicians' discharge decision taking. For example, in our earlier study, we found that clinicians who manage complex or chronic cases will often delay or not discharge patients.[2]

An earlier study confirmed that junior dermatology clinicians admit to avoiding patient discharge because writing discharge letters was time consuming.[4] Furthermore, consultants had mentioned that junior clinicians are risk averse to discharging patients.[2] Despite this, our study indicated that, unlike for senior clinicians, junior clinicians did not think that the discharge checklist helped with their thought processes. We recommend that trainees, consultants, dermatology clinical nurse specialists and clinical assistants should be educated about how to take appropriate outpatient discharge decisions and how to manage the process of discharge.

The Delphi methodology used is a widely accepted, dynamic group technique to achieve consensus among experts, such as by clinicians when faced with contradictory opinions when making decisions. Normally 16–28 participants are needed for combined or composite judgement;[32] in this study there were 17 participants. Group feedback is an important aspect of the Delphi process, but there is little

evidence about how feedback influences group performance.[32] Measurement errors are inevitable when (fallible) humans make decisions, hence a reliability index needs to be calculated.[38] Inter-rater reliability calculates the extent to which the raters consistently differentiate between different responses.[37] When the same person is doing the survey at different times (in this case three rounds of the Delphi) then the use of the ICC is a good measure of the consistency of participants' responses across the different time points.[37] The high ICC in this study demonstrates that the survey questionnaire yielded consistent response among the raters and therefore its repeated use by different raters will result in reliable results. In contrast, there was only fair inter-rater agreement of 0·27.

The Delphi exercise established appropriate items for the discharge checklist, but most clinicians felt that it did not help their thought processes. However, clinicians may not have insight into the multiple influences, sometimes inappropriate, on their clinical decision making, for example when the clinician is rushed[2] or when the clinician's mood is affected by the last patient seen.[4, 41] Disparities in perceptions between dermatology clinicians and patients may result in patients' discontent;[34] even the most competent clinicians may upset a patient by discharging them.[42, 43] The use of a checklist has the potential to allow patients to express their wishes without feeling challenged by a clinician's perceived dominance. Unless clinicians seek information about patients' wishes, some patients will accept a paternalistic process of decision making or be too nervous to highlight their doubts,[44] leading to the clinician having inaccurate perceptions and possibly making ill-informed decisions.

Clinicians are expected to discharge appropriately and in a timely fashion; the steps surrounding outpatient discharge are crucial to patient safety. There has been much attention to inpatient discharge planning[11, 12] and on how to reduce outpatient attendances.[45, 46] However, very few studies focus on how to improve outpatient discharge decision making.[20-22] The differences between outpatient and inpatient discharge are emphasized by comparing the items of our outpatient checklist with an inpatient checklist designed for patient use;[15] there are only three similar items.

Use of a rigorously developed checklist may avoid clinical errors. It may also support the thinking process of some clinicians who try to focus on the scientific or evidence base for decision taking, ignoring the nonclinical influences that are of equal importance. Clinicians using a checklist may feel they understand their patients better and be encouraged to relate to the general practitioner, assisting 'seamless' care. A patient experiencing the clinician's use of a checklist may have more insight into the limitations of expertise, may consider the finite healthcare budget and may be more confident knowing that their clinician has gone through a checklist.

The implementation of surgical checklists reduces or prevents errors or complications.[18, 19] However, despite the extensive publicity given to checklist use,[18] doctors are slow to adopt new practices, as implied by some clinician comments in this study.[47] We need to move towards more systematic patient-centred care to avoid preventable errors and potential litigation.

Reading through the checklist items may encourage clinicians to take more care over the discharge process. A completed checklist could also serve as proof of structured thinking and provide transparent documentation of the discharge process for audit purposes. The reasons for nondischarge of a patient would be documented by use of a checklist, which would be of benefit if the patient were seen by a different clinician at their next visit. The use of a checklist may also prevent inappropriate discharge; for example, a patient's noncompliance to medication might be due to confusion over treatment side-effects, and the use of a checklist could reveal this misunderstanding.

Although the checklist is designed for use in a dermatology clinic, none of the wordings are dermatology specific. The checklist may be of relevance and of value if used in outpatient clinics by other specialists, or individual specialties may consider developing similar checklists for their specific needs.

A checklist is an instrument to nudge[48] the decision maker subtly to consider pertinent issues in the decision-making process. It remains to be demonstrated whether the systematic use of an outpatient discharge checklist improves the quality and appropriateness of discharge decisions. The workload pressure and time constraints on clinicians may seem to make it difficult to use such a checklist routinely. However, if the checklist were demonstrated to improve the appropriateness of outpatient decision taking, and if this resulted in earlier discharge of patients, then it is possible that, overall, use of the checklist might result in greater efficiency and time savings in the outpatient clinic service. If usage of the checklist is proven helpful, then the checklist could be integrated into a clinical decision support tool[49] to reduce risks of error and to improve patient safety.

This study has several strengths. The Delphi method is appropriate to generate consensus and to evaluate consistency among a group of experts while maintaining strict confidentiality. Respondent bias was minimized as the consultants answered the questionnaires individually. The reliability of group judgement increases as the number of participants increases. Seventeen consultants took part in all three rounds of the Delphi survey (100% response rate), which may have increased the reliability of the ratings. We selected consultants from different regions to enhance the generalizability of the results. The involvement of the researcher (N.A.H.) who was also involved in the earlier part of the discharge decision project[1, 2] may have encouraged group consistency, adherence and improved decision performance.

The study also has limitations. There is no established rule to determine when consensus is reached. The number of experts representing an adequate sample in a Delphi study is unknown. Drawing clinicians from a higher number of trusts might have yielded different results. The researcher knew the respondents from the previous study[2] and this may have introduced bias. Validation for use in different healthcare systems might be required. The information exchange in a Delphi study is strictly controlled, compared with the more creative potential of face-to-face interaction. Response delay may be caused by ‘decision fatigue’ secondary to boredom or time constraints, affecting the accuracy of the results.

In conclusion, there is a need for clinicians to understand the importance of making appropriate discharge decisions. The use of a checklist may eliminate hidden biases and minimize preventable errors.[47] Although shared decision making is the bedrock of patient-centred care,[40] the decision to discharge a patient in an outpatient setting still lies in the hands of the clinician; using a checklist has the potential to result in more appropriate patient-centred decision taking, enhancing the quality of patient care. A ‘traffic-light’ design discharge information checklist for use in dermatology outpatients is described. However, the checklist items are all of relevance to any medical specialty and the checklist may be of use in other fields.

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Figure 1

Delphi study flowchart

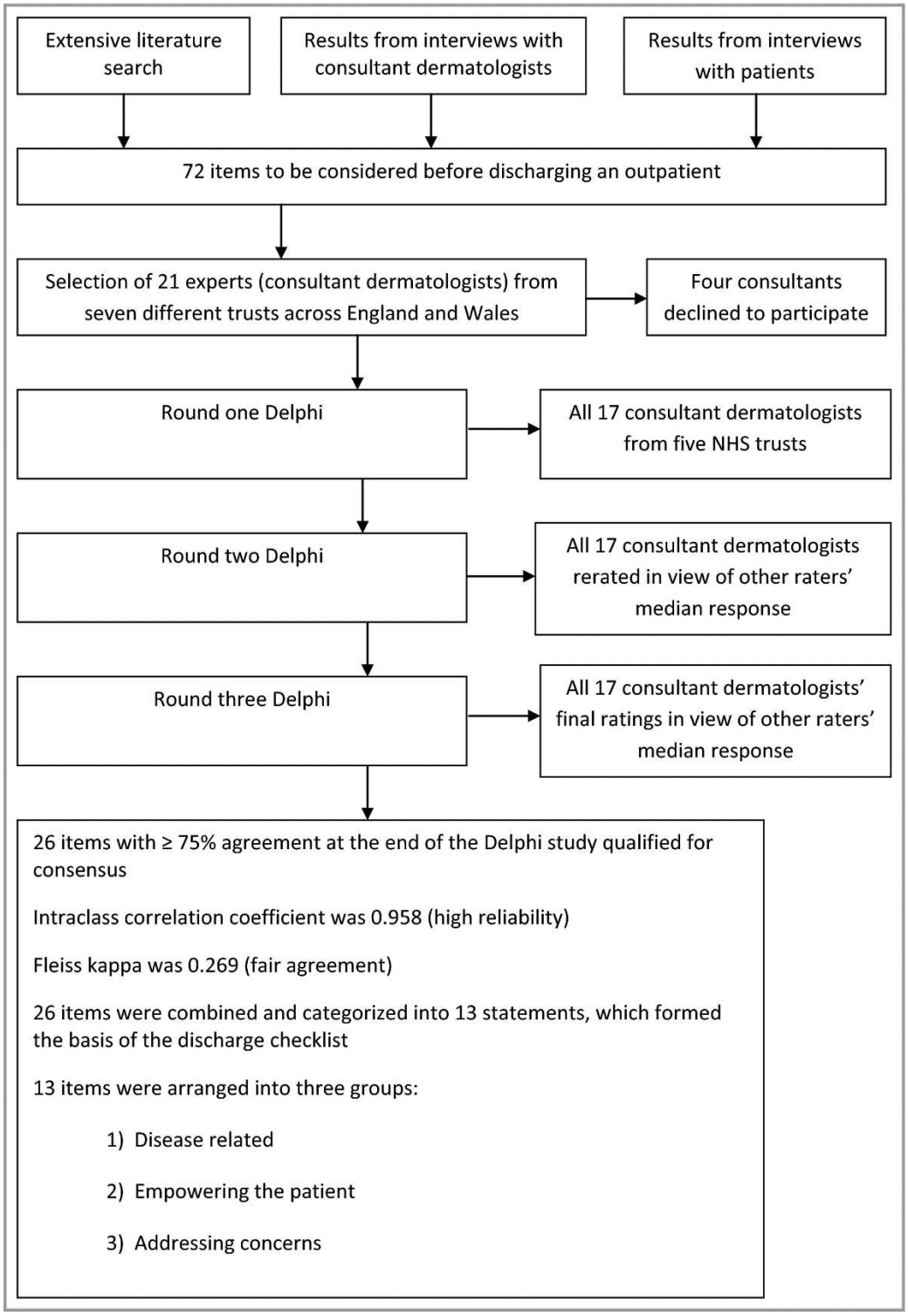

Figure 2

Example of one of the rater's replies in round 3 of the Delphi study

Round Three Delphi Questionnaire

1	**When considering discharge, how important is it to consider the type of diagnosis?**					
Unimportant	Of little importance	Moderately important	Important	Very important	Response	
				★	Group's response in Round 2 (median score)	
			✖		Your response in Round 1	
			x		Your response in Round 2	
			x		Your response in Round 3	
2	**When considering discharge, how important is it to consider the local discharge policy?**					
Unimportant	Of little importance	Moderately important	Important	Very important	Response	
		★			Group's response in Round 2 (median score)	
			✖		Your response in Round 1	
			x		Your response in Round 2	
			x		Your response in Round 3	
3	**When considering discharge, how important is it to make sure that patients can easily reaccess secondary care (dermatology clinic) if their skin problem worsens?**					
Unimportant	Of little importance	Moderately important	Important	Very important	Response	
			★		Group's response in Round 2 (median score)	
		✖			Your response in Round 1	
			x		Your response in Round 2	
			x		Your response in Round 3	

Figure 3

The 'traffic-light outpatient dischrage information checklist

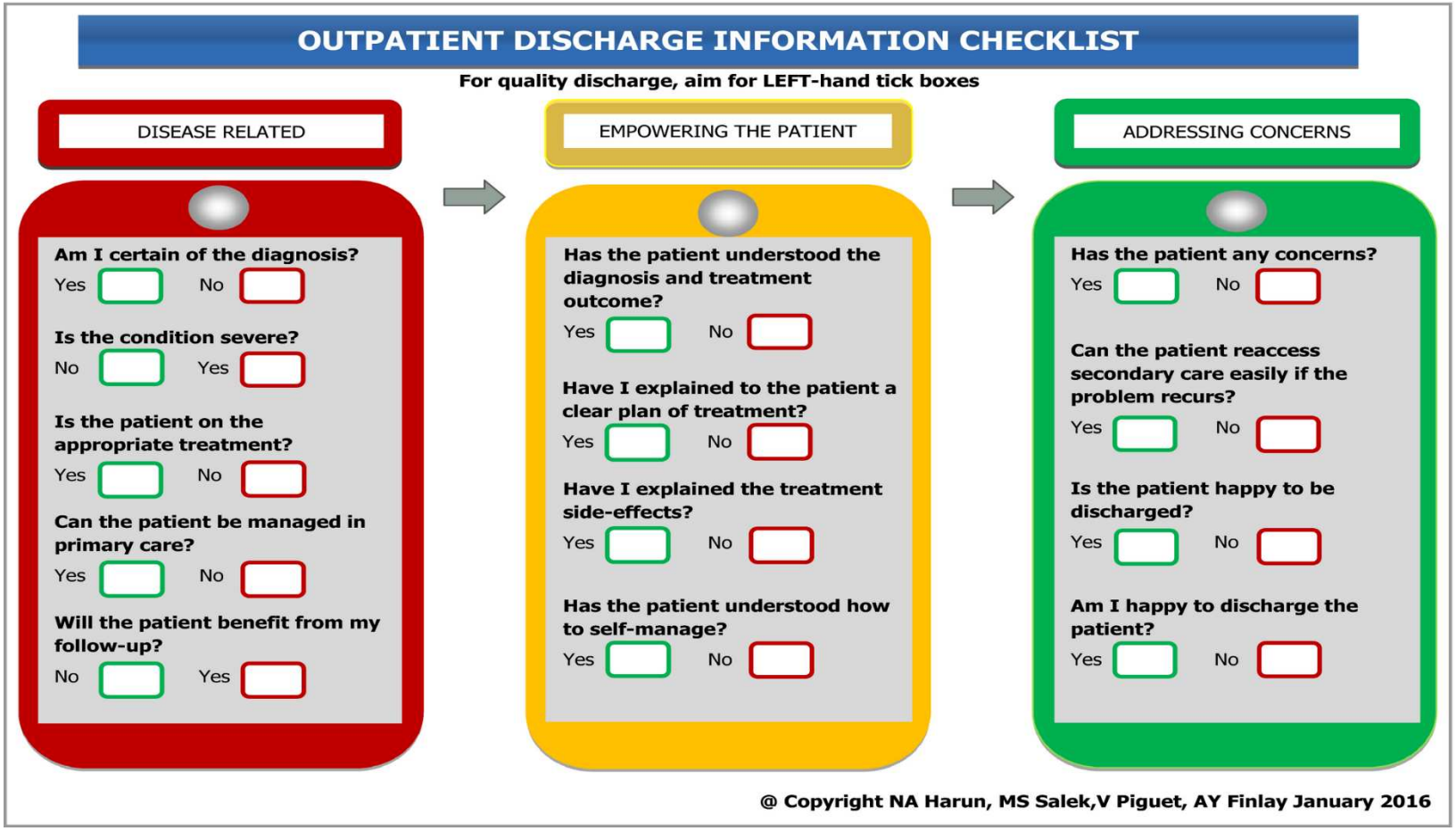

Table 1
The 26 items with ≥ 75% agreement at the end of round three

	Median	Level of agreement	Interquartile range of Likert scale	Degree of variance
1 To ascertain that the patient is on the appropriate treatment Very important	Very important	100%	4-5	0.11
2 To consider the type of diagnosis Very important	Very important	100%	4-5	0.15
3 To consider the severity of the diagnosis Very important	Very important	100%	4-5	0.19
4 To ascertain that the patient understands how to self-manage and monitor the skin problem	Very important	100%	4-5	0.19
5 To discuss the outcomes of both disease and management with the patient	Very important	100%	4-5	0.22
6 To address the patient's concerns Very important	Very important	100%	4-5	0.22
7 To have a clear and effective plan of treatment Very important	Very important	100%	4-5	0.22
8 To ascertain the availability of good primary-care support, e.g. GP, community nurse, social support groups, patient's advocate	Very important	100%	4-5	0.24
9 To ascertain that the patient knows about the treatment and side effects	Important	100%	4-5	0.26
10 To follow the patient's wishes not to be followed up Important	Important	100%	4-5	0.15
11 To consider the type and demands of the treatment plan currently used by the patient	Important	100%	4-5	0.24
12 To ascertain whether the patient's skin disease can be managed at the level of primary care	Important	100%	4-5	0.24
13 To consider patients' understanding of management information at discharge	Important	100%	4-5	0.26
14 To ask oneself, 'Will this patient benefit from further follow-up by me?'	Very important	94.1%	3-5	0.34
15 To consider the patient's wishes to be followed up by the GP instead of by secondary care	Important	94.1%	3-5	0.24
16 To consider the patient's psychological state of mind Important	Important	88.2%	4-5	0.18
17 To consider the complexity of the skin disease Important	Important	88.2%	3-5	0.25

18 To consider the presence of a carer for vulnerable patients Important	Important	88.2%	3-5	0.47
19 To ensure that the patient understands the skin diagnosis Important	Important	88.2%	3-5	0.25
20 To consider the patient's compliance with treatment Important	Important	88.2%	2-5	0.61
21 To ensure that the patient is happy and satisfied with the discharge Important	Important	88.2%	3-5	0.31
22 To consider one's own limitations of clinical expertise Important	Important	88.2%	3-5	0.31
23 To be certain of the patient's skin diagnosis Important	Important	76.5%	3-5	0.36
24 To ascertain the patient's easy reaccess to secondary care if the skin problem worsens	Important	76.5%	3-5	0.50
25 To discuss problematic cases with other colleagues Important	Important	76.5%	3-5	0.69
26 To consider the patient–carer or patient–parent relationship Important	Important	76.5%	2-5	0.61

Table 2
Grouping of the 26 items that qualifeid for the Delphi consensus into 13 items for the final checklist

Item/Statement	Items that were combined under one statement	Level of importance and percentage of agreement	Interquartile range of Likert scale	Variance
1 Am I certain of the diagnosis?	To consider the type of diagnosis	Very important (100%)	4–5	0_15
	To be certain of the patient's skin diagnosis	Important (76_5%)	3–5	0_36
	To discuss problematic cases with other colleagues	Important (76_5%)	3–5	0_69
2 Is the condition severe?	To consider the severity of the diagnosis	Very important (100%)	4–5	0_19
	To consider the complexity of the skin disease	Important (88_2%)	3–5	0_25
3 Is the patient on the appropriate treatment?	To ascertain that the patient is on the appropriate treatment	Very important (100%)	4–5	0_11
	To consider the type and demands of the treatment plan currently used by the patient	Important (100%)	4–5	0_24
4 Can the patient be managed in primary care?	To ascertain the availability of good primary-care support, e.g. GP, community nurse, social support groups, patient's advocate	Very important (100%)	4–5	0_24
	To ascertain whether the patient's skin disease can be managed at the level of primary care	Important (100%)	4–5	0_24
	To consider the patient–carer or the patient–parent relationship	Important (76_5%)	2–5	0_61
5 Will this patient benefit from my follow-up?	To ask oneself, 'Will this patient benefit from further follow-up by me?'	Important (94_1%)	4–5	0_22
	To consider one's own limitations of clinical expertise	Important (82_4%)	4–5	0_26
6 Has the patient understood the diagnosis and treatment outcome?	To discuss the outcomes of both disease and management with the patient	Very important (100%)	4–5	0_22
	To consider patients' understanding of management information at discharge	Important (100%)	4–5	0_26

	To ensure that the patient understands the skin diagnosis	Important (88_2%)	3–5	0_25
7 Have I explained to the patient a clear plan of treatment?	To have a clear and effective plan of treatment	Very important (100%)	4–5	0_22
8 Have I explained the treatment side-effects?	To ascertain that the patient knows about the treatment and side-effects	Very important (100%)	4–5	0_26
9 Has the patient understood how to self-manage?	To ascertain that the patient understands how to self-manage and monitor the skin problem	Very important (100%)	4–5	0_19
	To consider the presence of a carer for vulnerable patients	Important (88_2%)	3–5	0_47
	To consider the patient's compliance with treatment	Important (88_2%)	2–5	0_61
10 Has the patient any concerns?	To address the patient's concerns	Very important (100%)	4–5	0_22
	To follow the patient's wishes not to be followed up	Important (100%)	4–5	0_15
	To consider the patient's wishes to be followed up by the GP instead of by secondary care	Important (94_1)	3–5	0_24
	To consider the patient's psychological state of mind	Important (88_2%)	3–5	0_18

Table 3
Demographic characteristics of the 18 clinical dermatologists who took part in evaluating the checklist

Dermatology clinicians	Number (%)
Male	4 (22)
Female	14 (78)
Age (years), median (range)	35 (26–62)
Indigenous British	15 (83)
Ethnic minority	3 (17)
Consultants	4 (22)
Academic specialists	4 (22)
Specialist registrars	4 (22)
General practitioners with a special interest in dermatology	2 (11)
Clinical nurse specialist	3 (17)
Senior house officer	1 (6)

Table 4
Evaluation of the discharge checklist by 18 clinicians

Question	Yes	No
Did you find the checklist useful?	12 (67%)	6 (33%)
Did you think the process of thinking through the discharge decision was made much easier for you using the checklist?	3 (17%)	15 (83%)
Did you feel the information in the checklist used to guide your decision was inadequate?	0 (0%)	18 (100%)
Would you like to use the checklist in future consultations?	11 (61%)	7 (39%)